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SENATE BILL 2765
By Graves

AN ACT to amend Tennessee Code Annotated, Section 56-32-226, relative to TennCare prompt payment of claims.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-32-226(b)(2)(A), is amended by deleting the existing language in its entirety and substituting instead the following:

If a provider's claim is partially or totally denied in a remittance advice or other appropriate written or electronic notice from a health maintenance organization, or a provider's previously allowed claim is subsequently partially or totally denied by a health maintenance organization by an appropriate written or electronic notice, then the provider may file a written request to the commissioner to submit the claim denial to an independent reviewer as provided in subdivision (b)(3). In the event the provider receives no remittance advice or other appropriate written or electronic notice from a health maintenance organization either partially or totally denying a claim within sixty (60) calendar days of the health maintenance organization's receipt of the claim, then the provider may file a written request to the commissioner to submit the claim to an independent reviewer as provided in subdivision (b)(3). However, prior to sending this request, the provider must send a written request for reconsideration to the health maintenance organization which identifies the claim or claims in dispute, the reasons for the dispute and any documentation supporting the provider's position or request by the health maintenance organization. The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request and, in the event

that the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond, the health maintenance organization will inform the provider with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider so long as the reconsideration decision is issued within sixty (60) calendar days after receipt of the reconsideration request. If the health maintenance organization continues to deny the provider's claims or the health maintenance organization does not respond to the reconsideration request within the time frames established in this subdivision (b)(2)(A), then the provider may file a written request with the commissioner to submit the claims to an independent reviewer as provided in subdivision (b)(3).

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it